

FILED DEC 12 1945
Registration District No. **318**

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 24 days
(Specify whether _____)

In this community 26 Years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 2812 Thomas St
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ROBERT C HOUSTON, JR.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 2. Color or race Col.

5. Color or race Col.

6. (a) Single, widowed, married. Divorced Widowed

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased October 16, 1870
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>1</u>	<u>15</u>	hr. _____ min. _____

9. Birthplace Indenolia Texas
(City, town, or county) (State or foreign country)

10. Usual occupation Undertaker

11. Industry or business _____

MOTHER FATHER {

12. Name Robert C. Houston, Sr.

13. Birthplace Indenolia, Texas
(City, town, or county) (State or foreign country)

14. Maiden name Celia Taylor

15. Birthplace _____ Texas
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Pauline E. Dickerson

(b) Address 2812 Thomas Street

17. (a) Burial (b) Date thereof 12-7-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director [Signature]

(b) Address 3445 Washington Ave

19. (a) DEC 5 1945 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 1
year 1945 hour 2 minute 30 A. M.

21. I hereby certify that I attended the deceased from Nov. 6, 1945 to Dec. 1, 1945
that I last saw him alive on Dec. 1, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Ca. of Larynx with metastasis

Duration Unk

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy None

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(b) Means of injury _____

23. Signature B. N. Phillips (M. D. or other) _____
Address 2601 N. Whittier Date signed 12/3

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Chas. L. Howell

Licensed Embalmer No. *2452*

P.O. Address *2834 Gamble*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.